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Bringing Anglo-Governmentality into Public Management Scholarship: The Case of Evidence-based Medicine in UK Health Care

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ABSTRACT

The field of public administration and management exhibits a limited number of favored themes and theories, including influential New Public Management and Network Governance accounts of contemporary government. Can additional social science-based perspectives enrich its theoretical base, in particular, analyzing a long-term shift to indirect governance evident in the field? We suggest that a variant of Foucauldian analysis is helpful, namely “Anglo-governmentality.” Having reviewed the literatures, we apply this Anglo-governmentality perspective to two case studies of “post hierarchical” UK health care settings: first, the National Institute for Health and Clinical Excellence (NICE), responsible for producing evidence-based guidelines nationally, and the second, a local network tasked with enacting such guidelines into practice. Compared with the Network Governance narrative, the Anglo-governmentality perspective distinctively highlights (a) a power–knowledge nexus giving strong technical advice; (b) pervasive grey sciences, which produce such evidence-based guidelines; (c) the “subjectification” of local governing agents, herein analyzed using Foucauldian concepts of the “technology of the self” and “pastoral power”; and (d) the continuing indirect steering role of the advanced neoliberal health care State. We add to Anglo-governmentality literature by highlighting hybrid “grey sciences,” which include clinical elements and energetic self-directed clinical–managerial hybrids as local governing agents. These findings suggest that the state and segments of the medical profession form a loose ensemble and that professionals retain scope for colonizing these new arenas. We finally suggest that Anglo-governmentality theory warrants further exploration within knowledge-based public organizations.

INTRODUCTION

The field of public administration and management exhibits a limited number of favored themes and theories, such as the currently influential New Public Management (NPM) and Network Governance accounts of contemporary government and governing. Can additional theoretical perspectives usefully be brought in to enrich its theoretical base?

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A major shift in many jurisdictions during the past 30 years (including the United Kingdom) has been from traditional vertically integrated public bureaucracies to decentralized forms, such as executive agencies (Pollitt et al. 2004), partnerships with nonstate partners (Rhodes 2007), network-based organizations (Ferlie et al. 2012), and hence, more indirect steering mechanisms. Existing interpretations conceptualize these developments through the NPM narrative (Hood 1991), with ideas from organizational economics, or a Network Governance narrative (Newman 2001; Osborne 2010; Rhodes 1997, 2007), from (admittedly heterodox) political science. Can these major developments be seen through an alternative theoretical prism?

A “supply side” perspective suggests proliferating theoretical perspectives across various social sciences. Within the neighboring field of Organization Studies (Clegg and Hardy 1996), distinct European and American schools are evident, with Europeans likely to cite European social theorists, where Foucault has proved influential (Marsden and Townley 1996). We ask whether Foucauldian theory can be useful in the analysis of governance in contemporary public service organizations.

We will explore the contained volume of current public management writing adopting a broadly Foucauldian perspective. We argue that an “Anglo-governmentality” perspective (Miller and Rose 2008) provides new insights into steering mechanisms in the contemporary State, distinct from standard NPM and Network Governance accounts.

We apply this Anglo-governmentality perspective to governance mechanisms associated with the evidence-based medicine (EBM) movement in UK health care, taken as a major public policy arena. The UK National Health Service (NHS) is a large public service organization with a high political profile, a substantial budget funded through taxation, and repeated reorganizations: It is a strategic site for organizational analysis within public management. Initially, we introduce a core methodological text produced by the UK National Institute of Health and Clinical Excellence (NICE) designed to promote evidence-based clinical guidelines. We then adduce local case study data on governance within a “managed network” in sexual health services, exemplifying EBM-based governmentality in action. We conclude that the Anglo-governmentality perspective is distinctive from both NPM and Network Governance paradigms and adds explanatory value.

Theoretically, we develop Anglo-governmentality accounts by highlighting novel hybrid “grey sciences,” which include clinical as well as economic elements. We explore the subjectification of clinical-managerial hybrids as active governing agents, using Foucauldian concepts of “technology of the self” and “pastoral power.” More broadly, we see the health care State and segments of the medical profession as a loose ensemble. Elite professionals appear to be more resilient than Miller and Rose (2008) suggest, with scope to recolonize new health policy arenas. We finally explore our study’s limitations and the possible wider contribution of an Anglo-governmentality perspective.

LITERATURE REVIEW: THREE ALTERNATIVE ACCOUNTS OF INDIRECT GOVERNMENT

New Public Management Narrative

Core NPM ideas come from public choice theory and organizational economics (Niskanen 1971), constituting a theory of government failure and proposing

market-orientated reform doctrines. In the absence of market forces, this theory suggests that the State will overproduce goods and services. The strategic aim is to shrink the State (e.g., by privatizing public services), reduce taxation, limit operational political oversight, and so reduce politicians' irresponsible promises. These ideas provide reform doctrines persuasive in the political domain, aimed at "downsizing" large public sectors and making them less distinctive from the private sector (Dunleavy and Hood 1994; Hood 1991).

Core NPM policy devices include constructing markets and quasimarkets; empowering management against public sector unions and professions; and transparent measuring of agency performance (Ferlie et al. 1996). The old hierarchies of public bureaucracies are broken up by quasimarkets and executive agencies (Pollitt et al. 2004); so central ministries downsize and retreat from micro management. Although direct command lessens, strong contracts, overt incentives, and performance-management regimes seek to align the strategic intentions of the policy center and the operational behavior of "autonomized" service delivery agencies. The core State does not give up top-down strategic control but reasserts it in new ways. The United Kingdom is a high-impact jurisdiction for NPM reforms (Hood 1995), and the NHS is a high-impact sector (Ferlie et al. 1996).

Although critics see the UK NPM reforms as confined to the 1980s and 1990s (Benington and Moore 2010; Dunleavy et al. 2006; Osborne 2010) and now superseded, recent empirically grounded work on the NHS in London (Trenholm and Ferlie 2012) sees these earlier reforms as highly embedded, if dysfunctionally so, and difficult to shift.

Network Governance Narrative

NPM reforms have been subjected to sustained academic critique, referring to their fragmenting effects (Dunleavy et al. 2006) and eroded systemic capacity (Sullivan and Skelcher 2002) needed to handle "crosscutting" public policy issues; overemphasis on operational management and hollowing out of creative public policy, which then leads to preventable policy "disasters" (Dunleavy et al. 2006); and failure to consider democratic accountability or the political process, hence damaging the legitimacy of public policy (Benington and Moore 2010).

From the late 1990s, an alternative "network governance" narrative emerged from (often heterodox) political scientists (Newman 2001; Osborne 2010; Rhodes 1997, 2007; Sullivan and Skelcher 2002), which critiqued NPM and advanced alternative reform doctrines. In the United Kingdom, this work informed New Labour's policy agenda (1997–2010) for "modernizing government." This writing gets beyond conventional parliamentary and central government-centric accounts of UK political institutions and brings in more actors. Rhodes (1997, 2007) developed the image of the "hollowed out state," in which functions migrate from the core UK nation state upward (to the European Union), sideways (to executive agencies), and downward (to strong regions) simultaneously. Intersectoral networks emerged to unpick the fragmenting damage of earlier NPM reforms, particularly in crosscutting issues (Sullivan and Skelcher 2002) going beyond the jurisdiction of a single agency (e.g., crime prevention).

Newman's (2001) early overview of the network governance narrative highlights policy and institutional shifts. These included a move from competition back to

collaboration and the use of networks and intersectoral partnerships (rather than the hierarchy/contracts mix of NPM) as characteristic policy instruments. The Evidence-based Policy movement became influential as part of “postideological” repositioning by New Labour. As we explore, the health care networks of the early 2000s were not traditional tacit networks, deriving from public services professions, but were managed networks, explicitly supposed to “deliver” central targets locally. So the State can be seen as broadening the actors in the health policy process but still seeking a privileged steering role.

Although NPM-led accounts (and their economics-derived thought categories) are radically distinct from Foucauldian governmentality, some authors operating with the Network Governance narrative have affinity with Foucauldian ideas (e.g., [Bevir and Rhodes 2003, 2010](#); [Newman 2005](#)), so the intellectual boundary here is porous. Admittedly, Foucauldian work has little interest in the institutional shifts presaged in the network governance literature, such as “hollowing out” ([Rhodes 1997, 2007](#)), the move from quasimarkets to network-based working ([Newman 2001](#); [Sullivan and Skelcher 2002](#)), and Evidence-based Policy ([Newman 2001](#)). [Osborne’s \(2010\)](#) account of New Public Governance draws on network theory rather than governmentality. However, some network governance authors explore Foucauldian themes of discourse and identity formation. Thus, [Newman \(2005\)](#) and [Newman and Clarke \(2009\)](#) use “governmentality” to explore the construction of local governing agents and of publics. [Bevir and Rhodes \(2003, 2010\)](#) advance an interpretive and discursive approach to public administration, citing Foucault among others. We explore the overlap or separation between network governance and Anglo-governmentality accounts later.

GOVERNMENTALITY AND ANGLO-GOVERNMENTALITY

We now argue that the concept of “governmentality,” as outlined by Michel [Foucault \(1979, 1991, 2007\)](#) and specifically as developed by the “Anglo” or “London governmentality” ([Bevir and Rhodes 2010](#); [McKinlay and Pezet 2010](#); [Miller and Rose 2008](#)), describes aspects of governance in contemporary public organizations. This writing ([Dean 1999](#); [Foucault 1979, 1991, 2007](#); [McKinlay and Starkey 1998](#); [Miller and Rose 2008](#)) reconceptualizes traditional government as “governmentality.”

Rather than directly controlling public service organizations through Weberian bureaucratic command or NPM-style contracts and targets ([Ferlie et al. 1996](#); [Hood 1991](#)), governmentality operates broadly to structure “the conduct of conduct” ([Foucault 1982](#)), leading actors to think and act as those governing desire. Foucauldian analysis does not focus narrowly on core political institutions (unlike conventional political science; [Rhodes 2007](#)) but on the wider “political economy” (including knowledge bases and associated techniques). He refers to a “linked ensemble” rather than a single dominant power center, decentering the State ([Bevir and Rhodes 2010](#)). He is interested in dominant political rationalities and in how they evolve and link to concrete technologies of governing. Foucault’s own definition of “governmentality” ([Foucault 2007](#), 108) refers to “the ensemble formed by institutions, procedures, analyses and reflections, calculations and tactics . . . that has the population as its target, political economy as its major form of knowledge and apparatuses of security as its essential technical element.”

Foucault distinctively analyses the nature of power. His important concept of a “power–knowledge nexus” couples State agencies and apparatuses with emerging professions and their knowledge bases, notably medicine, law (Foucault 2007, 108), and now accounting (Miller and Rose 2008). The State and the learned professions are linked in an “assemblage,” rather than being in opposition, as assumed by the NPM paradigm with its deregulation of professional cartels. For example, the State licenses psychiatry to identify, detain, and treat the mentally ill, so psychiatrists are charged with simultaneously monitoring across and intervening within local populations to control social risk and danger.

Foucault’s concept of governmentality conceptualizes power as “constituted by the interaction of disciplinary and pastoral techniques together with the behaviours of individuals and populations.” (McKinlay & Pezet 2010, 487). In “*Discipline and Punish*” (Foucault 1977), Foucault explores “disciplinary power” through which people internalize external rules. He draws upon Bentham’s “panopticon” model for a reforming prison, in which prisoners’ behaviors are made individually knowable and visible to an all-seeing and ever-surveying center. Because they can potentially be seen at any time by a warder, prisoners internalize external rules and reform their own behaviors. In contemporary public organizations, an “electronic panopticon” may use new information technologies that enable organizational centers to survey operational fields continually through electronic reporting systems and remotely influence what they do (Zuboff 1988).

Foucault’s later works (Foucault 2007, 184) explore “pastoral power” as “a prelude to governmentality,” which helps explain how people internalize external rules about how they should behave. We will use the concept of “pastoral power” in our case analysis later. Foucault (2007) describes how the Christian pastorate (priests, abbots, and monks) internalized the Church’s teachings. They were taught to think and behave as “shepherds” serving their “flock,” sacrificing their own needs in service to each and every “sheep,” role modeling Christ’s teachings to encourage moral behavior among their congregations. Pastoral power affected parishioners, leading them to internalize the Church’s teachings too. Parishioners, like monks in training, were encouraged to confess thoughts and behaviors that fell below moral standards as a path to salvation (Foucault 1990a). Thus, the pastorate and parishioners alike internalized the Church’s teachings and drew upon its knowledge and standards of moral conduct within so-called projects of “technologies of the self,” which act to “cultivate” the long-term evolution of the self (Foucault 1990b; Starkey and McKinlay 1998).

Foucault (2007, 199) notes: “In its modern forms, the pastorate is deployed to great extent through medical knowledge, institutions, and practices . . . medicine has been one of the great powers that have been heirs to the pastorate.” Like clergy, doctors are taught to act in the best interests of their patients and put patients’ interests above their own. Patients, like parishioners, are encouraged to trust doctors and bodies of medical knowledge and to confess thoughts and behaviors that might lead to illness, to be saved from disease. As medical knowledge is increasingly constructed through EBM, how does this shift affect pastoral power among doctors? How do they internalize EBM principles to serve patients and cultivate their evolving professional identities?

This Foucauldian perspective has effects at the organizational level of analysis (Starkey and McKinlay 1998) as it suggests that “soft” organizational control systems (education and training, personal development and coaching) may become as

important as “hard” discipline. It is through such pastoral power that people may acquire new identities (as a selective consumer of public services [Miller and Rose 2008] or an “enterprising” public manager).

So, Foucault moved from an earlier focus on discipline to desire (Starkey and McKinlay 1998), including the possible creation of one’s own desired and ethical new identity through a “technology of the self” project. McKinlay and Pezet (2010) draw out implications for contemporary “high commitment” organizations with a discourse of empowered workers and leader managers, suggesting a “good” manager will be motivated to lead, coach, and inspire the workforce, rather than simply discipline them.

We comment that Foucault offers an original perspective on indirect modes of government. Although Foucauldian ideas have not had a major impact on mainstream public administration and management scholarship, traditionally positivist and institutionally focused (Rhodes 2007), some scholars—aligned with the Network Governance perspective—have used aspects of his perspective. One grouping adopts broadly postmodern, discursive, and culturally orientated approaches, which we see as another way of interpreting Foucauldian ideas, distinct from the Anglo-governmentality school we use. Thus, Bogason (2005) suggests that a “post modern” public administration moves away from modern rationalization and old-style Weberian bureaucracies toward new conditions of fragmentation, decentralization, individualization, spontaneity, and internationalization. Bevir and Rhodes (2003, 2010) have developed an interpretive and postmodernist approach to public administration. Citing Foucault alongside others, Bevir (2004) argues for an “interpretive turn” in public administration scholarship. This stance leads to a more bottom-up, locally contingent, and interpretive approach, taking account of prevalent discourse (language is seen as a power source), meanings, beliefs, and contingent practices enacted by local actors. This theoretical stance indicated highly ethnographic methods, used to study beliefs held by senior civil servants (Bevir and Rhodes 2010, 103).

Interestingly, Newman’s work developed from uncovering key institutional features of network governance (Newman 2001) to later work drawing on Foucauldian governmentality. Her study (Newman 2005) of the United Kingdom’s “micro politics of modernization” highlights its characteristic use of transformational leaders drawn from senior public service managers as subjectified change agents. Newman (2005) moves from the conventional Foucauldian focus on self-regulating citizens to construction of transformed identities (through leadership programs) among local governing agents. Although this work has some similarities with our analysis, Newman (2005) draws more on Foucauldian concepts of discourse and cultural practices rather than ideas of pastoral power and the trajectory of the self utilized here. Within a discursive perspective, Newman and Clarke (2009) explore the construction of publics within contemporary UK public policy arenas and their relationship with the neo-liberal and postneoliberal State. Their book explores various political and discursive practices within a broad cultural studies perspective. They ask how the language of “publicness” is constructed. They discuss the political strategy of “governing through community,” citing UK-based Community Safety Partnerships, as an attempt at indirect rule and at promoting the formation of self-governable subjects within the field of crime prevention. The broad theme arises: What are the political and cultural logics of rule being articulated within discourse?

ANGLO-GOVERNMENTALITY

Foucauldian ideas have strongly influenced neighboring social science fields, notably sociological accounting research (Armstrong 1994; McKinlay and Pezet 2010) and Organizational Studies (McKinlay and Starkey 1998). The tone here appears less post-modern, culturally based, or discursive than the authors reviewed earlier and is more concerned with identifying concrete technologies of power–knowledge, unsurprisingly so given the centrality of measurement systems within accounting research. The Organizational Studies literature considers (again unsurprisingly) managing through a committed and “postbureaucratic” style and constructing new managerial identities through “technologies of the self.”

Miller and Rose (2008) offer an intriguing Anglo-governmentalist account of the advanced neoliberal State (Chapter 8). They suggest that this State still seeks to govern, but in a broader and indirect manner, contrasting with an orthodox Foucauldian conceptualization of governmentality (Mitchell 1991), where there is no such conception of a State (at least with a capital S). McKinlay and Pezet (2010, 494) note: “The ‘London governmentals’ fundamental insight is that management, in the broadest sense, can be thought of in terms of how it attempts to manage at a distance, constructing images of the citizen, the consumer, employee, systems of measurement that both represent and produce significant social effects . . . the London governmentals retain the centrality of the state, albeit as smaller, but operating in a more strategic, brokerage or commissioning role.” The advanced neoliberal State (where the United Kingdom is an ideal typical case) reorganizes dominant political rationalities, aligned with novel and indirect technologies of government (Miller and Rose 2008, 80) and within regimes of regulated and earned autonomy. Although it sheds direct ownership, it still seeks to steer. Within a power–knowledge perspective, the growth of new sciences (such as the “psy sciences”) offer a newly rational basis (Miller and Rose 2008, 9) for managing deviant subjectivities and may indeed be licensed by the State and form a governing ensemble.

Three characteristic shifts in the advanced neoliberal state are suggested (Miller and Rose 2008, 212). The first is a *new relation between expertise and politics*. The old self-regulatory world of public services professions is breached by new but expansive calculative technologies sponsored by the governmental center. These notably include the “accountization” of public services through budgeting, accountancy, financial management, and audit-based reforms (Power 1997), enabling the behavior of public service professionals to be recorded and challenged, eroding their ability to protect traditional self-regulating enclosures. The “grey sciences” of accounting—defined as “*these know-hows of enumeration, calculation, monitoring, evaluation*” (Miller and Rose 2008, 212)—are modest and mundane, often overlooked by scholars, yet pervasive in quietly reshaping professional work. The study of governmentality therefore requires “*attention to the particular technical devices of writing, listing, numbering and computing that render a realm into discourse as a knowable, calculable and administrative object . . .*” (Miller and Rose 1990, 5). Specific intellectual technologies inscribe information locally and move it to the center, through written reports, charts, statistics, or aggregated and hierarchized data. We examine technical devices of analysis in the EBM arena from this perspective.

A second shift is the *pluralization of social technologies*. An institutional “destatization” process (Miller and Rose 2008, 212–3) detaches the central state from its old apparatuses (e.g., breaking up NHS vertical line management and eroding the doctrine of direct ministerial accountability). Government fragments into a collection of quasi-nongovernmental organizations, regulators, purchasers, providers, and (of particular interest) “standalone agencies,” with autonomy and operational responsibility. The creation of NICE as a technical agency, giving (strong) advice to government on the vexed question of health care rationing is a major example.

The third shift (Miller and Rose 2008, 212) is a *new specification of the subject of government*, referring to the identity shifts and strong values characteristic of Foucauldian analysis. Within the advanced neoliberal state, broad discourses of enterprise and responsibility are pervasive. Thus, patients are recast as consumers, choosing between options in a health care quasimarket. Newman (2005) examines the construction of “new selves” among public managers as transformational change leaders. Using the Foucauldian “*technology of the self*” concept, we suggest that self-surveillance, enrolment in a governmentality project, and long-term self-development may create reformed identities among senior staff as committed change leaders (McKinlay and Pezet 2010; Starkey and McKinlay 1998).

Governmentalized arenas may combine pervasive analytic technique with strong values. The study of Hasselbladh and Bejerot (2007) investigating “governmentalized” Swedish health care notes its appeal to common goods, strong moral codes, and socio-cognitive constructs. Foucauldian concepts can characterize new indirect governing technologies and multivocal arenas, not reducible to a simple managerialization project. Although clinical control over work practices remains substantial, new health policy arenas were here colonized by various expert groups drawn from management, health economics, patient rights, and informatics. Perhaps surprisingly (Hasselbladh and Bejerot 2007), this new rationalized form of action successfully generated energy and excitement. This perspective suggests value-driven macro-rationales lie on top of particular analytic techniques. Appeals to higher-order rationales and claimed common goods (such as legitimate evidence-based change), as rhetorical mobilizing devices within governmentality projects, should be examined (Ferlie et al. 2012).

A governmentality project may encounter resistance as well as achieve enrolment. Prisoners can and do riot as well as adopt reformed conduct. McKinlay and Pezet (2010, 494) note, “*studying governmentalisation requires us to attend not just to the programmes of the powerful but to their operation and to the manifold ways that individuals, groups and populations absorb, comply with and resist these projects.*” Hence, we explore a case study of implementing evidence-based “best practice” in a locally managed sexual health network, focusing on actions of local clinical change leaders to illuminate “technology of the self” and “pastoral power” arguments.

BRIEF HISTORY OF NHS POLICY

The NHS is a major and politically visible UK public service, funded through taxation and (so far) almost entirely delivered by public sector organizations. Private financing and provision remains much smaller than in the American health care system. It

displays a range of historically strong professions (especially medicine) and a well-developed biomedical research base, so it is a knowledge-intensive setting.

A brief NHS policy history highlights the influence of two different public policy reform narratives. In the 1980s and 1990s, under Margaret Thatcher's Conservative Government, the NHS was subjected to major NPM reforms (Ferlie et al. 1996; Hood 1991) including introducing general management to tighten line management (1985) within organizations; creating operationally decentralized provider units (NHS Trusts); an internal quasimarket designed to mimic market forces (1990/7) and audit, performance-measurement and management systems (e.g., Audit Commission). The Department of Health was downsized, and operationally autonomous agencies spun out.

The later period of Tony Blair's New Labour governments (1997–2010) was associated with (an admittedly ambiguous and limited) tilt (Newman 2001; Rhodes 1997, 2007) toward “network governance.” Post-NPM policies moved “from competition to collaboration,” in part through “managed networks.” These networks were designed to reinforce a lateral and “whole-systems” approach and also to ensure that localities met centrally set performance targets in exchange for substantial increases in public funding. There was a rhetorical backlash against bureaucracy/NPM and a renewed stress on reengaging public service professionals. At the same time, NPM-style performance-measurement and management regimes were intensified, with public league tables to “name and shame” poor performers. There was a postideological commitment to “what works,” with EBM emerging as a powerful new movement and informing a wider discourse of Evidence-based Policy. Within health care, evidence-based National Service Frameworks were developed in key areas (e.g., cancer care, mental health), which placed limits around local clinical autonomy but were also constructed in consultation with leading clinicians and other stakeholders.

So how can we characterize these novel NHS governance modes? Can the Anglo-governmentality prism add explanatory value? After considering methodology, we present two case studies that suggest that Anglo-governmentality is a useful theoretical lens.

METHODS

This article seeks to apply a novel theoretical framing (Anglo-governmentality) to make sense of changing modes of governance in the UK NHS by examining two case studies. Within political science, George and Bennett (2005, 5) consider the potential of case study-based research to complement the formal modeling methods often used. Case studies seek to investigate “various forms of complex causality.” So there is a question about how case study methods relate to and develop theory. Can they move beyond surface-level description or one-off accounts? George and Bennett (2005, 5) define the case study approach as “the detailed examination of an aspect of a historical episode to develop or test historical explanations that may be generalizable to other events.” Comparative and longitudinal designs here appear stronger than single descriptive cases (Yin 2009). There is a trade-off between thick description (internal validity) and conceptualization (external validity), but we emphasize the need for case studies to relate to theory (rather than using hypotheses as characteristic of a

quantitative paradigm). [George and Bennett \(2005\)](#) support mixed-methods research involving quantitative elements, but we choose to connect case study work with theory to promote external validity.

Within the flourishing case study-based tradition within UK health policy research ([Exworthy et al. 2012](#)), [Marinetto's \(2012\)](#) methodological analysis similarly suggests weaknesses in the use of “intrinsic” cases, often localized, of a small scale, and descriptive. [Marinetto \(2012\)](#) acknowledges that more sophisticated designs are apparent, with large-scale and purposeful selection of comparative cases, citing the study of [Pettigrew et al. \(1992\)](#) with reference to NHS strategic change processes. Our local case study is drawn from a large-scale study designed with a similar comparative logic.

Case Study 1: Textual Analysis of the Documents of the National Institute of Clinical Excellence

NICE's Web site (www.nice.org.uk) contains much downloadable but, so far, underutilized documentary material. [Bryman \(1989\)](#) suggests that such archival data are non-reactive (unlike interviews), helpfully providing entry into closed and elite dominated arenas: Thus, written reports of public enquiries can be used to investigate normally closed arenas. [Bryman \(1989\)](#) reminds us that documents are not neutral texts but produced through social construction. They are interesting precisely because of such social construction: Textual analysis can chart analytical techniques manufactured and employed with precision. So, textual analysis provides an entrée into the “what” of governmentality.

Earlier Foucauldian analyses of EBM ([Ceci 2004](#); [Shaw and Greenhalgh 2008](#)) analyzed documentary materials (a committee of enquiry and policy texts, respectively) but did not explore concrete analytical techniques. Elsewhere, [Miller and Rose \(1990\)](#) examined analytic techniques in a national accounting project in postwar France as part of an indicative planning system, finding (flawed) attempts to construct a national input/output table as a technique of inscription.

[Bryman \(1989\)](#) recommends that textual analysis should be extended with interview or observational material. An observation-based study of [Davies et al. \(2006\)](#) of the Citizens Council meetings of NICE used Foucauldian discursive categories to understand the rules of speaking brought to meetings by the powerful (e.g., norm of politeness) that blunted oppositionist discourse. By itself, textual analysis provides little insight into actual behaviors or important subjective themes in Foucauldian literature, such as identity formation and shifts. We therefore explore the theme of subjectification in a second empirical case study drawn from our larger study ([Ferlie et al. 2010](#)).

Case Study 2: Enacting Evidence-based Organizational Change in a Managed Sexual Health Network

Our second case study explores the local enactment of evidence-based guidelines, in one local case. The larger study consisted of four contrasting “pairs” of health care-managed networks set up in the early 2000s under New Labour, including two sexual health networks. The final project report is available on the following web site: www.netscc.ac.uk/hsdr. Scholars of governmentality have been criticized, for ignoring

“how those individuals, groups and organizations affected by these systems of power and knowledge conform, resist and adapt” (McKinlay and Pezet 2010, 488). Adducing case study work that reveals actual organizational behaviors responds to this criticism.

The comparative case-based design paid special attention to the role of context and organizational process (Eisenhardt 1989; Langley 1999; Pettigrew et al. 2001) in shaping patterns of service change. In each case study, the research team followed through a major service change objective (the so-called “tracer issue”) over time, which the network had set for itself to achieve. We examined its fate over time. The team used standard qualitative methods consistently across the cases: semistructured interviews (228) with a spine of common questions, combined with documentary analysis and attendance at meetings.

We wanted to move from narrative descriptions of surface-level observations to underlying themes and generating structures (Pentland 1999). The case study analyses should relate to theory rather than being purely descriptive. Rather than adopting a purely inductive approach or grounded theory, we took an “iterative” approach and moved between data and theory, using both induction and deduction (Eisenhardt 1989; Langley 1999). We undertook an initial literature review of major theoretical approaches evident (including governmentality), which informed the interview proforma, and sensitized the researchers in the field. After intensive group discussions toward the end of the project, the team wrote eight case studies in the same format to aid comparative analysis and theorization. The overarching theoretical orientation that emerged as the most powerful was “governmentality,” and this final theoretical direction was reflected in the cross-case analysis and the final report (Ferlie et al. 2010).

Our assessment was that a governmentality perspective was powerful in explaining governance systems in four cases (including the Sexual Health network discussed here) but weaker in the other four (although resistance to governmentality was as interesting as enrollment). The case study explored here is a sexual health network, which focused on the “tracer issue” of redesign of local sexual health services in line with evidence-based national guidance. The fieldwork (2008) included semistructured interviews with a range of 24 network stakeholders and observations of nine meetings.

GOVERNANCE OF EVIDENCE-BASED MEDICINE IN UK HEALTH CARE: TWO CASE STUDIES

Case Study 1: The Evidence-based Clinical Guidelines of the National Institute of Clinical Excellence

The rise of EBM and evidence-based clinical guidelines represent major health policy shifts internationally (Timmermans and Berg 2003). It has (literally) undergone institutionalization in agencies such as the UK National Institute of Health and Clinical Excellence (renamed in 2006, but commonly still known as the National Institute of Clinical Excellence [NICE] as its former better-known name) and the American Agency for Health Care Research and Quality. Often held up as an international role model, the NICE produces many evidence-based clinical guidelines, advising on what can be purchased on the NHS tariff. How does it produce these guidelines? What knowledge bases does it draw on?

NICE (created in 1999) is a specialist NHS agency producing evidence-based clinical guidelines on clinically and cost-effective health care, removing direct responsibility for politically contentious rationing of health care from Ministers and the Department of Health. It has substantial operational autonomy, with its own Board, Chair and Chief Executive, although its work is aligned with that of the Department of Health. Its first and long-standing nonexecutive chair was an eminent academic physician and pharmacologist. There is no political representation at the Board level. NICE lies outside conventional NHS line management. It is a small agency, outsourcing technical appraisal work to associated research centers. It operates as an expert advisory agency, with a well-developed technical apparatus.

Producing Clinical Guidelines: Experts, Knowledge, Analytic Techniques, and User Involvement

NICE's *Manual of Guidelines* is a core methodological text (NICE 2009), outlining a standardized process for producing clinical guidelines. It discusses preferred methodologies and analytic techniques. We examine this text to address the governmentality-related themes discussed earlier.

Mobilizing Rationalities: Best International Evidence, Transparency, Collaboration, and Evidence-based Service Change

The introduction (NICE 2009, 9–11) outlines an overall rationale, namely “best international evidence; transparency; collaboration and evidence-based service change.” This vision goes beyond a focus on cost-effectiveness to include broader values, stating: “*all types of NICE guidance are developed using the best available evidence and involving stakeholders in a transparent and collaborative way. Stakeholders include national organizations that represent patients and carers, health care professionals, the NHS, organizations that fund or carry out research and companies that have an interest in the guidance being developed.*”

“Best evidence” is international as well as national. The text urges guideline developers to use international material. “Transparency” recurs as a theme; thus, the text states that guidelines “*are developed using recognised methods that are sound and transparent.*” The *Manual* itself provides transparency into the technical process of guideline construction. As a guiding value, the text stresses “collaboration” with patients and carers in the coproduction of knowledge. As Mykhalovskiy and Weir (2004, 1067) note, EBM proponents “*are democratizers, eager to invite their addressees— patients, clients, students and others—into the culture and regimes of evidence-based decision-making,*” which in theoretical terms, can be seen as part of the wider evidence-based “ensemble” of governmentality. NICE's Citizens' Council (Davies et al. 2006) developed novel processes to involve patients and carers in guideline development. Finally, the text suggests organizational activism and the desire to translate NICE's clinical standards into evidence-based changes to service delivery:

“Good clinical guidelines change the process of health care, improve outcomes for patients and ensure efficient use of health care resources. They can be used to develop standards for assessing the clinical practice of health care professionals, to educate and train health care professionals, to help patients make informed decisions and to improve communication and shared decision making between patients and health care professionals” (NICE 2009, 10)

So, the text suggests a broad, mobilizing, and perhaps even inspirational rationale, as well as particular analytic techniques.

Power–Knowledge Nexus: Bounded Pluralism, Leading Professionals, and International Research Networks

Ceci (2004) and Shaw and Greenhalgh (2008) have explored the EBM power–knowledge nexus. We additively examine the recommended membership of NICE’s Guideline Development Groups, outlining who is in the room and who outside? The suggested membership contains patient and carer members but appears largely professionally and medically dominated. The *Manual* gives an example of Guideline Development Group membership for the Clinical Guideline on heavy menstrual bleeding: two gynecologists; one obstetrician; two family doctors; one specialist nurse; one radiologist; one epidemiologist; one clinical director; two patient and carer members, with support from NICE’s technical team. This advisory apparatus mixes many leading professionals with technical support and some patient and carer representation.

The core of the power–knowledge nexus lies in our view in international networks of health services researchers (so, the ensemble is international and based in a scientific episteme rather than bounded by one national agency). These scientific networks alone have the legitimated expertise to define the technical knowledge and associated methods underpinning guideline construction. This argument supports the professional restratification thesis (Freidson 1994), whereby knowledge (and administrative) elites become separated from the clinical rank and file. Knowledge-based arenas, such as NICE, are readily colonized by the clinical academic elite (Spyridonidis and Calman 2011).

The *Manual* states that a guideline “is based on the internationally accepted criteria of quality, as defined in the *Appraisal of Guidelines Research and Evaluation (AGREE) instrument*.” The AGREE Web site (www.agreetrust.org) indicates it is a charitable foundation bringing together international guideline researchers “to advance the science of practice guidelines” and provide an assessment framework. AGREE II is presented as a new valid and reliable international tool for the assessing guidelines (Brouwers et al. 2010).

The *Manual* refers to the GRADE (Grade of Recommendations, Assessment, Development, and Evaluation) international working group of researchers. NICE is migrating to the GRADE model. GRADE authors (Guyatt et al. 2008) argue that guidelines should be based on a hierarchy of patient-important outcomes (preferably ranked in a scale), which are simple, explicit, and transparent. The quality of studies is assessed as follows “in the GRADE approach to quality of evidence, randomised trials without important limitations constitute high quality evidence. Observational studies without special strengths constitute low quality evidence” (Guyatt et al. 2008, 995), clearly ordering evidence into an explicit hierarchy. GRADE seeks to offer summary evidence readily understood by external stakeholders.

The Cochrane Collaboration is a third important global research network. The *Cochrane Handbook of Systematic Reviews of Interventions* is commended as a methodological source (<http://handbook.cochrane.org/>; Lefebvre et al. 2008). The *Manual* specifies preferred electronic databases to be searched, including the *Cochrane Database of Systematic Reviews* and the *Cochrane Register of Controlled Trials*. International networks of health services researchers appear to have successfully defined methods, including ranking evidence in a hierarchy.

Emergent Grey Sciences: Information Science, Systematic Reviewing, and Health Economics

Three new “grey sciences” (Miller and Rose 2008) are apparent. The *Manual* indicates that the technical team supporting guideline production should include an information specialist, a systematic reviewer, and a health economist (all novel roles and knowledge bases). The information specialist should identify literature, designing search terms, identifying electronic databases to be searched, and then construct an electronic database. The *Manual* states that the review should be systematic rather than interpretive: “the systematic identification of evidence is an essential step in clinical guideline development. Systematic literature searches undertaken to identify evidence of clinical and cost effectiveness should be thorough, transparent and reproducible” (NICE 2009, 54).

The second emerging “grey science” is systematic reviewing, which plays a critical role in interpreting evidence. The *Manual* gives guidance on how systematic reviewers should assess study quality. Checklists are provided to assist the reviewer to assign the study to the appropriate type and to assess quality (including qualitative research). A standard data extraction sheet should produce a standardized and explicit “evidence table” for each study. A systematic reviewer should synthesize the evidence in an “evidence profile,” using GRADE software (NICE 2009, 72).

The systematic reviewer’s key tasks include setting review questions, selecting and assessing abstracts using clear inclusion criteria, undertaking critical appraisal of evidence using a validated system, distilling evidence into tables, synthesizing evidence into statements, and keeping an audit trail: “the systematic review process used should be explicit and transparent.”

The meta-analysis of Randomized Control Trial data is commended using material from the NHS Center for Reviews and Dissemination and the *Cochrane Collaboration Handbook*. We consider techniques of analysis and inscription within these “grey sciences” below, taking a critical example from health economics. The *Manual* outlines preferred techniques of calculation in the heartland of studies of clinical interventions, where there is a clear hierarchy of evidence with meta-analyses of Randomized Control Trials at the apex (NICE 2009, 70, 72). Although these methods are preferred, it is stated that other research methods can be appropriately used in other fields. For example, questions about patient experience may appropriately draw on qualitative research and we add trial-based methods may be problematic in psychotherapy and counseling, where the dynamics between health care professionals and patients/clients are essential elements of practice (McGivern and Fischer 2012).

The *Manual* argues that cost-effectiveness matters as well as clinical effectiveness. So, health economics is a third grey science. A health economist should provide technical expertise in economic evaluation and modeling. The aim is to assess cost-effectiveness rather than provide crude cost estimates, using measures of output and input/output ratio, where the important technique of the “quality-adjusted life year (QALY),” which provides a health-related quality-of-life measure (one to zero scale), is key. The “incremental cost-effectiveness ratio (ICER)” specifies the relationship between measures of higher utility and higher costs. Although NICE has never laid down explicit cost guidelines, there are “rules of thumb” in the text. An ICER of less than £20,000 for a QALY gained is generally considered cost-effective. For an ICER between £20,000 and £30,000, an advisory group will have to make a case, and a

strong one for one above £30,000. We comment these “rules of thumb” critically shape the new drugs and treatments that are approved.

So these “grey sciences” provide distinctive techniques of analysis and inscription within newly developing knowledge bases and help produce many guidelines in a standardized manner. Interestingly, they are not based on accountancy or audit-based knowledge or techniques (in contrast to [Miller and Rose 2008](#)), although health economics has a concern with transparent resource use. Information science mixes established librarian-based knowledge, new Information and Communication Technologies, and searchable electronic databases. Systematic reviewing brings in analytic techniques from Health Services Research. There is here a concern with measuring clinical outcomes as well as resource use. Clinical research knowledge has not been entirely displaced by resource-based knowledge: rather they merge in a novel hybridized form.

Mobile Electronic Databases and Texts Moving from the Periphery to a Surveying Center

New Information and Communication Technologies can create an “electronic panopticon” ([Zuboff 1988](#)), whereby information moves from the periphery to a surveying organizational center through “*systematic and rigorous searches*” ([NICE 2009](#), Appendix C, 162) of electronic databases that capture and define relevant knowledge. These databases are virtual, internationally mobile, readily searchable, reviewable, and then summarized by NICE’s technical teams. Appendix C in NICE guidelines ([NICE 2009](#), 162) states “*there are core databases that should have been searched for every question.*” They include Medline, the Cochrane Database of Systematic Reviews, and the Cochrane Central Registry of Controlled Trials. Using electronic databases to move hierarchized research-based information to the surveying center underpins guideline production.

Case Study 2: Enacting Evidence-based Guidelines in a Managed Sexual Health Network

Our wider study ([Ferlie et al. 2010](#)) explored how a set of English health care–managed networks was governed, given the lack of conventional hierarchies or market forces. They were “managed” networks, responsible for delivering national service delivery targets locally despite no hierarchical or market power. The networks had “responsible autonomy,” with operational freedom to deliver targets but only within central health policy frameworks (e.g., in National Service Frameworks), built up with many of the analytic techniques already explored. Clinical–managerial hybrids (rather than general managers) tended to lead these managed networks, because securing strong professional “engagement” was a key objective. The Sexual Health Network examined in this article contained five hospitals, including a Teaching hospital and several Primary Care Trusts (local commissioners of health care services) in a large UK city. The Network covered a diverse population of about 2 million people, so it was a large-scale site.

Network activity was framed by a national policy framework, reflecting a period of health policy activism. The National Strategy for Sexual Health and HIV ([Department of Health 2001](#)) proposed managed networks for human immunodeficiency virus

(HIV) treatment and sexual health services, outlining standards and guidance. It (Department of Health 2001, 2) starts by asserting “*this strategy has been developed by involving service users, members of target groups and professionals in the field.*” The text includes an epidemiological assessment of Sexual Infection caseloads, calling for “*the development of nationally agreed guidelines on HIV treatment and care, together with locally agreed operational guidelines in the form of care pathways.*” Epidemiological forms of knowledge and data are well developed in this text. More trials for antiretroviral drugs to treat HIV were also strengthening an underpinning biomedical research base amenable to more conventional trial-based knowledge (as in NICE guidelines). Although the text acknowledges that the evidence base for preventive work was imperfect, its ambition was to develop an evidence base for effective health prevention work.

A subsequent national policy document, “Choosing Health” (Department of Health 2004) announced funding to modernize sexual health services and set a target that all patients should get an appointment within 48 h of first contact with services (reducing waiting lists was a key health policy target generally).

Local policy makers in the case study site sought to implement evidence-based guidelines developed by clinical/professional groups working in sexual health rather than a government agency (although these guidelines were reinforced by the National Sexual Health Strategy, reflecting crossover of personnel). This National Steering Committee for the Sexual Health Strategy again mixed leading clinical academics, nonacademic clinicians, health services researchers, and civil servants, with cross-representation from key clinical associations. The Chair was a senior clinical academic from a research-intensive university and the Vice Chair, a senior medical civil servant. However, there was strong representation from voluntary sector organizations so that this policy arena appears somewhat more pluralist.

The local Sexual Health Network was formally led by an Executive Board, containing multidisciplinary representatives of various patient, voluntary, and specialist clinical and professional groups and organizations. The Network had no statutory authority but used advisory authority to change clinical practices. In practice, decisions were made in the clinical or professionals subgroups and by leading clinicians rather than the Executive Board. We argue that the way these leading professionals internalized, interpreted, used, and implemented evidence-based standards and the manner in which the network placed peer pressure on clinicians to conform to such standards constructed a successful local governmentality project.

Two key Network leaders were its Clinical Director, a sexual health consultant and head of sexual health services at the Teaching hospital, and a Specialist HIV Commissioner, previously a sexual health nurse at the Teaching Hospital. The Clinical Director was described as “the prime mover” locally. She had been personally involved in developing national sexual health guidelines and had published an article in a leading medical journal arguing for evidence-based practice in sexual health care. Rather like an abbot inculcating pastoral power among monks, as described earlier (Foucault 2007), she personally championed EBM. She commented:

“We should all be working to [national sexual health care] standards. . . . We can, as a network, help pull that together and I think we need to do more of that . . . peer pressure and support to help them improve quality . . . do big selling to your colleagues.”

In line with the governmentality perspective, her focus shifted from individual patient care in one hospital to the needs of the whole local patient population. She commented:

“What motivates me? . . . Team working, delivery . . . On a good day I [as a clinician] can give them [patients] the best service . . . it’s wanting to replicate that throughout the service.”

Evidence-based standards and managing health services to meet them formed a major part of the clinical director’s professional identity and “cultivation of self” (Foucault 1990b) and she worked to persuade other clinicians to adopt evidence-based sexual health care practices too.

The second key leader was a Specialist HIV Commissioner, involved in writing local sexual health standards reflecting the needs of the local population. He too was involved in getting sexual health professionals to internalize evidence-based thinking and commented: “*I do genuinely believe that most of it is about benefitting people.*” Network leadership was a small collective group, rather than an individual, based on a group of clinicians who drew on evidence-based standards which—when internalized—contributed to “technologies of self” projects.

Implementing evidence-based standards and redesigning services to meet the national 48-h waiting target provided a “burning platform,” focusing attention within the network. Local purchasers were incentivized that local sexual health services should meet national targets because they would be financially penalized by the national financing system if not.

The Teaching Hospital had previously redesigned its sexual health services on a walk-in basis and achieved the 48-h target. The Network organized workshops to share best practice around service redesign. Network members updated care protocols, visited other services, and considered ways in which services could be improved.

The Network conducted an audit of its sexual health services, making local sexual health practices and outcomes visible and knowable against national standards and targets, thus introducing the disciplinary element of governmentality. Sharing these data among clinicians created “peer pressure” to enroll into the evidence-based ensemble and to change their practices accordingly. The network clinical director noted:

“We got bunches of clinicians together in rooms, ran workshops and shared best practice. We had a detailed questionnaire looking at [local] practice . . . shared all that . . . four out of five units are doing this [meeting standards]. . . . The network had an impact [creating] . . . peer pressure, about modernizing practice.”

This can be seen as “pastoral power,” in which clinicians are encouraged to think about best practice and disclose their thoughts and current practices in relation to external evidence-based standards and thus to cultivate their professional selves. This process led them to internalize evidence-based practices. However, the Specialist HIV Commissioner noted:

“One particular hospital . . . had a problem . . . there were concerns over outcomes and standards. [The network] review of all . . . the units . . . identified where there were problems and then made some recommendations to the hospital where there were problems. . . . And that worked . . . was a very positive outcome.”

Here, governmentality operated as an *indirect* form of power. The Network did not directly tell the doctor to change substandard clinical practices (indeed, it had no authority to do so), but by making clinical practices visible against national standards, it constrained his field of possible actions and acted upon his identification as a “good doctor.” As a result, the doctor leading the service decided to leave. His replacement then acted on the network’s recommendations and adopted evidence-based standards of best practice, achieving the 48-h waiting target.

So we see how a governmentality project developed at the local level. Network leaders, involved in developing EBM at both national and local levels, had internalized such knowledge and reconstructed their own professional identities accordingly. They were centrally involved in assembling elements of governmentality, socially constructing local sexual health services in governmental terms, and using “disciplinary power” by auditing and making them visible against evidence-based standards. Once practices were visible, we then see the operation of “pastoral power” linked to clinical “peer pressure.” They encouraged clinicians to discuss and think about their services and clinical practices, identify with evidence-based standards, and willingly redesign services that did not comply with national standards. Indeed, failing to do so would undermine their professional identities.

CONCLUDING DISCUSSION AND THEORETICAL CONTRIBUTION

So, our interpretation of the case studies suggests novel health policy arenas—both nationally and locally—with weak traditional governance modes, namely absent (quasi) markets but also weak NPM-style line management. Moving beyond old-style tacit clinical networks, the center constructed “managed” networks as a tool for local EBM implementation, generating some internal enthusiasm in the locality studied. We now consider two theoretical questions that arise. First, what is the broad theoretical contribution of the existing Anglo-governmentality perspective (especially Miller and Rose 2008), compared with the Network Governance narrative with which (as argued) there is a more permeable boundary than with NPM-based accounts? Second, can our cases develop Anglo-governmentality theory? The arguments are summarized in table 1 for ease of reference.

First, what is the added theoretic value of an Anglo-governmentality perspective? We start by noting that Foucauldian thought generates a distinctive analysis of power. The first additive contribution lies in the specific concept of the *power-knowledge nexus*. So where there is knowledge, there is power; and where there is power, there is knowledge. Miller and Rose (2008, 9) give the example of the rise of “psy sciences,” such as psychology, with their promise to manage deviant subjectivities rationally. The State and the learned professions here form a loose ensemble, which acts to classify, regulate, and reform social deviance. The advanced neoliberal UK health care state analyzed here is similarly linked to embedded professional and expert advisory apparatuses (e.g., NICE’s Guideline Development Groups; National Sexual Health Advisory Group), which supply valued technical knowledge and limit direct political action in health care rationing. This stance reconceptualizes state/profession relations away from the presumed binary split of the NPM paradigm or seeing public services

Table 1
The Key Arguments of Anglo-Governmentality and Network Governance Contrasted Together with Our Contribution

| Characteristics | | Examples | Network governance paradigm |
|--|--|---|--|
| Existing Anglo-governmentality theory (Miller and Rose 2008) | | | |
| 1. Power-knowledge nexus (Miller and Rose 2008, 9) | New sciences that claim to manage deviant subjectivities “rationally”; the learned professions and the State as ensemble | The “psy sciences” such as psychology; evidence-based medicine’s technical apparatus | Radically distinct: professions are just one of many legitimate stakeholders |
| 2. New relation between politics and expertise (Miller and Rose 2008, 212) | Invasion of the world of public services professionals by external, pervasive yet mundane control technologies: financially based “grey sciences”; “accountantization” | Audit; financial and budgeting controls; performance-measurement systems | Radically distinct: Evidence-based Policy as a “postideological” shift in politics; little interest in or critique of “techniques of inscription” |
| 3. Pluralization of social technologies (Miller and Rose 2008, 212) | “Destatization”; breaking up of large vertically integrated public bureaucracies | Quangos and executive agencies; from public ownership to regulators; erosion of direct democratic control and new partnerships with business | Some overlap: ‘hollowing out’ of the state (Rhodes 1997, 2007); but distinctively stresses the reintegrating role of networks and remobilization of civil society (Newman and Clarke 2009) |
| 4. New specification of the subject of government (Miller and Rose 2008, 213) | “Enterprise culture”; the public services client becomes a consumer | The choosy consumer of public services; choice as a political value; active personal risk management of life; cultivation of responsible and healthy lifestyles | Distinct: focus on the remaking of local publics rather than of individual citizens (Newman and Clarke 2009) |
| 5. The steering role of the advanced new liberal State (Miller and Rose 2008, 210) | The state still steers but in new and more indirect ways | We adduce the major example of NICE in health policy | Radically distinct: Rhodes (2007): bottom-up approach to the decentered state; the state is not a privileged actor |
| Our contribution | | | |
| 6. Hybrid knowledge and grey sciences | Mix of professional- and resource-orientated knowledge and analytic techniques | QUALY, ICER, systematic reviews | No account |
| 7. Subjectification of local governing agents: clinical-managerial hybrids | Professional-managerial hybrids as local governing agents; technology of the self and pastoral power as underlying concepts | High-energy style; postbureaucratic; use professional peer pressure to influence colleagues | Some overlap: Newman (2005) on ‘subjectified’ public managers uses governmentality |

Note: QUALY, quality-adjusted life year; ICER, incremental cost-effectiveness ratio.

professionals as just one of many legitimate stakeholders for inclusion within policy networks as in the Network Governance paradigm from which it is in this respect radically distinct.

The second distinctive theoretical contribution of Anglo-governmentality lies in its concept of pervasive “grey sciences,” originally coming from accounting or financial management but now colonizing the world of public services professionals. Such mundane yet pervasive “techniques of inscription” can quietly reshape professional work practices or even modes of thought, without direct command. Within our cases, examples would be the “*Guidelines Manual*” (NICE 2009; specifically, Information Science, Systematic Reviewing and Health Economics), and similar rationalities are evident in the National Sexual Health Strategy. These grey sciences complement or even displace overt hierarchical power or market forces. These indirect control technologies provide standardized and technically grounded guidelines over a vast field, transferring what might otherwise be a highly political process of health care rationing to an expert-dominated domain. The technical “rules of thumb” used in NICE’s guidelines have strong implications for which drugs and treatments are funded by the NHS and hence for health policy. The core methodological expertise needed to develop these grey sciences lies in our view with international expert groups of Health Services Researchers (linking to the power–knowledge nexus), despite some counterbalancing patient-based knowledge apparent in NICE’s decision making. The radically distinct network governance paradigm (Newman 2001), by contrast, treats the Evidence-based Policy movement as part of “postideological” macro-repositioning and does not focus on or critique concrete techniques of analysis as indirect control technologies.

Miller and Rose (2008, 212) thirdly refer to a pluralization of social technologies as a key development, involving destatization, the spinning out of special agencies (such as NICE), and the breakup of large public bureaucracies (consistent with an NPM analysis, albeit more critical in tone). Miller and Rose (2008) suggest that this is a lifeless world where local democratic control and political accountability erode and opaque “partnerships” with business and other social actors take their place. Network governance authors (Rhodes 1997, 2007) note these developments within a similar “hollowing out of the state” analysis but distinctively suggest that bottom–up networks emerge to unpick fragmenting NPM reforms, aided by remobilized civil society (Newman and Clarke 2009). Although there is overlap, a Network Governance account is less pessimistic in tone than Anglo-governmentality in relation to the scope for bottom–up and collective political activity.

A fourth analytic feature of Anglo-governmentality (Miller and Rose 2008) counterbalances its focus on pervasive rational technique with a characteristically Foucauldian interest in “subjectification.” These authors refer to the recasting of the subjects of governmentality as “enterprising selves,” making choices, adopting responsible lifestyles, and managing personal risks. Network Governance accounts (Newman and Clarke 2009), by contrast, discuss the remaking of local publics more than enterprising individuals. We consider the extension of this Anglo-governmentality perspective to the subjectification of local governing agents later.

A fifth and final assertion of Anglo-governmentality is that the advanced neoliberal State reconfigures but does not disappear. The State enrolls a broader range of actors, uses indirect technologies, and devolves operational control but still seeks to

retain strategic control. By contrast, [Rhodes \(2007\)](#) takes a more radically decentered view: specifically, post-NPM networks are of a bottom-up nature and contain no special role for the State. Indeed, excessive top-down steering will deform networks and suffocate their core features through overt direction. Our case material supports the Anglo-governmentality view—NICE is a special agency that aligns its work with that of the Department of Health. National Strategic Frameworks place bounds around “allowable” local clinical autonomy and define good practice. Managed networks are expected to deliver national policy objectives locally and can be performance managed, as the center retains reserve powers of intervention. The network studied managed to hold top-down and bottom-up principles in successful tension, generating ownership and enthusiasm locally while implementing national targets. In some arenas, the reformative ambitions of the advanced health care State become more ambitious, notably the National Sexual Health Strategy’s attempts to reform the sexual behavior of the population.

Our cases develop the Anglo-governmentality theoretical perspective further in two ways. First, we stress the subjectification of local governing agents rather than reformed citizens. In the local sexual health network, NPM-style line managers have been supplanted by professional-managerial hybrids who identify with the EBM agenda. These hybrids adopt a hands-on and energized style in local enactment. They draw upon the disciplinary power of local clinical audit against clear national standards and clinical “peer pressure” to internalize and comply with evidence-based standards. These hybrids exhibit long-term tracks of career development consistent with a technology of the self-perspective, migrating to more managerial roles, and perhaps even identities, over time. They can be seen as using a form of “pastoral power” in relation to their clinical peers. Our analysis has some similarities with [Newman’s \(2005\)](#) interesting work on the micropolitics of modernization of the UK public services, which highlights the role of active local managers and uses a governmentality theoretical framework. However, we bring in additional Foucauldian concepts of the “technology of the self” and “pastoral power.”

Second, we found a pattern different from that in the study of [Miller and Rose \(2008\)](#) in terms of “grey sciences.” There were indeed novel grey sciences, displacing traditional craft-like notions of clinical practice. But they cannot be seen as a pure “accountization” project with techniques coming into the health care world from outside: rather they combined a concern for measuring costs (health economics) and clinical outcomes. So, internally generated clinical knowledge has not been simply displaced by resource-based techniques, rather the two combine in a knowledge hybrid.

Broadly speaking, our findings bring a focus on the adaptive behavior of public services professions (notably, medicine) into Anglo-governmentality, noting their potential to construct hybrid forms. Thus, we found energized clinical-managerial hybrids as local governing agents and a health economics/clinical outcome knowledge hybrid as an underpinning rationality. The analysis of the “accountization” by [Miller and Rose \(2008\)](#) suggests a one-way process of importing such techniques, which then colonize professionals’ work practices. Taking the Foucauldian notion of the power-knowledge nexus operating as a loose “ensemble” rather than a fixed power center, we suggest that segments of the medical profession (notably managerial and knowledge elites, [Spyridonidis and Calman 2011](#)) work with the health care state yet retain some autonomy and adaptive potential (see [Waring 2007](#), on clinical behavior in analogous

patient safety arenas) or even engage in a “reverse colonization” of State-led attempts to steer their practices by capturing advisory machinery and defining legitimate rationalities.

What are the limitations of our study? One objection might be that from two worked examples, only modest conclusions can be drawn. One response is that our large-scale managed health care network-based study suggested that four of eight cases (Ferlie et al. 2010) displayed strong characteristics of Anglo-governmentality, so that the perspective appears to have wider (if still partial) validity. NICE is a strategic case in its own right, given the volume of guidelines it produces and the lack of exploration of its operation by social scientists. We seek to ensure that our cases are not purely descriptive but relate to Anglo-governmentality theory so that theoretical generalizability (Marinetti 2012) becomes more possible. A second objection might be that the analysis describes but does not explain the shift to governmentality-based organizing. We concede the analytic description presented is only the first stage in a long journey and we intend to explore underpinning reasons in future work.

Third, critics could see health care as a special sector characterized by an exceptionally well-developed science base, strong methodological convergence on preferred knowledge, and powerful professions. So, further work in such related sectors as social care, education, criminal justice (with weaker professions and less well-developed science bases, as conventionally understood), science policy, and the climate change-policy arena (which also has a strong science base) could explore its wider relevance. The perspective may have particular application within knowledge-based and professionalized public policy settings. An Anglo-governmentality perspective helpfully enriches the theoretical repertoire available to public management scholars in such settings. We now suggest both further theoretical explication of this complex literature and wider empirical exploration beyond UK health care.

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